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Testimony
Insurance and Real Estate Committee
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SB 210, SB 211, H.B. 5208 and H.B. 5210

Chairman Kelly, Chairman Larson, Chairman Scanlon and Representative Sampson and members of the Insurance and Real Estate Committee. Thank you for the opportunity to submit testimony in support of Senate Bills 210, 211 and to express my support for House Bills 5208 and 5210 as well. It has been an honor and pleasure to work with Senator Looney, members of the Public Health and Insurance Committees and other legislators from both sides of the aisle over the last several years on health care reform. These bipartisan efforts have resulted in significant and often precedent setting health care legislation designed to promote a transparent, competitive and affordable health care system. While our agenda for this year is relatively modest, I believe these proposals will continue to improve access to affordable care for the citizens of Connecticut. I want to also thank Senator Gerratana and Senator Somers for their support of these bills.

S.B. 211 An Act Concerning the Burden of Proof During Adverse Determination and Utilization Reviews

SB 211 would clarify that when an insurer denies coverage for medical treatment that the patient' s own physician has deemed medically necessary based on its belief that such treatment is, in fact, NOT medically necessary, the burden of proof in any appeal of that denial should be on the insurer. This seems to me to be a simple matter of fairness. The patient has paid for an insurance policy that promises to cover certain medically necessary services provided by a participating provider. The patient has gone to a participating provider who has determined, based on his or her professional medical judgement, that certain treatment is necessary. The insurance company should not be able to override or substitute its medical judgment for that of the provider unless it can establish a lack of medical necessity.

The need for this provision has become all the more obvious in light of recent revelations by a health insurance medical director in California. The doctor acknowledged under oath that he routinely denied coverage for physician ordered treatment without ever reviewing the patients' medical records and often without professional expertise or knowledge of the patients' specific medical condition. California's Insurance Commissioner was quoted as saying *"If the health insurer is making decisions to deny coverage without a physician actually ever reviewing the medical records, that's of significant concern to me ... and a potential violation of the law."* Since these revelations, several state insurance commissioners, including Commissioner Wade, have promised to investigate these practices. https://www.cnn.com/2018/02/11/health/aetna-california-investigation/index.html *("California Launches Investigation Following Stunning Admission By Aetna Medical Director")*; http://www.modernhealthcare.com/article/20180215/NEWS/180219943 *("Six State Regulators Now Scrutinizing Aetna Prior-authorization Practices")*

Cursory and unsupported denials of medical coverage are clearly inappropriate. Given that the insurer has accepted premium payments in return for a promise to cover certain medically necessary services, yet has a financial incentive to deny coverage, it seems appropriate to me to place the burden of proof in such denial on the insurer. It also seems appropriate to give the benefit of the doubt to the patient's own treating physician, rather than allow the insurer to substitute its medical judgment and put the burden back on the patient.

S.B. 210 An Act Concerning Surprise Medical Bills for Laboratory Services

Public Act 15-146, which was one of the first major pieces of health care legislation that Senator Looney and I worked on together, included some of the strongest provisions in the nation protecting consumers from surprise out of network medical bills. Surprise medical bills occur when a patient goes to an in network provider - a hospital, surgery center, physician office etc. -but then, without informed consent, is treated by an out of network physician. This can sometimes occur when an ancillary provider, such as an anesthesiologist, is brought in to assist with a procedure. Prior to the passage of PA 15-146, the patient, despite having specifically gone to an in network facility, would receive a surprise bill from the out of network provider. In some cases, these surprise bills could amount to thousands of dollars.

Under PA 15-146, the out of network provider must either notify and receive consent to treat and bill the patient or accept the insurer's in network rate. They cannot balance bill the patient, unless the patient has consented. This protects the patient, who paid for insurance and did what was required of him or her by going to an in network facility, while also ensuring that the provider is paid for his or her services. It also reduces billing disputes between insurers and out of network providers by providing a clear and fair reimbursement mechanism. A recent national study conducted by the Commonwealth Fund recognized Connecticut as one of just six states with comprehensive and effective surprise bill statutes.

SB 210 would simply add out of network lab services to this existing framework, which was always our intent. Often, facilities refer blood work or other lab services directly to a lab without the patient's knowledge as to where the work is being sent or whether it is an in network lab. Under this provision, if the lab is out of network it would have to notify the patient and obtain consent. Otherwise, it would be paid the in network rate and be prohibited from balance billing the patient.[1]

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[1] I want to note that our current statute for surprise emergency room bills, while following the same framework in terms of holding the patient harmless from a surprise ER bill, actually reimburses ER providers in that situation slightly differently. Instead of using the insurer's in network rate, an independent benchmark is used based on charges for similar services. This provision was based on New York State law. However, we understand that this benchmark may be unintentionally inflationary. It is completely appropriate and essential to protect patients from surprise ER bills. Patients' have little say in which ER they are taken to, and we do not want patients delaying emergency treatment in order to find and get to an in network hospital ER. We are happy to work with insurers, this committee and others to address this narrow concern regarding the ER reimbursement benchmark in a way that is fair to both payers and providers. We want to be clear, however, that SB 210 has no relationship to this issue as it does not address ER services.

In addition to SB 210 and SB 211, I would like to express my support for the following bills as well:

1. **H.B. 5208 An Act Concerning Mammograms, Breast Ultrasounds and Magnetic Resonance Imaging of Breasts**. This bill ensures that all forms of mammography, including breast tomosynthesis, are covered equally by insurance with no addition copays or deductibles.

2. **H.B. 5210 An Act Mandating Insurance Coverage of Essential Health Benefits and Expanding Mandated Health Benefits for Women, Children and Adolescents.** This bill would codify the essential health benefits required under the ACA and require coverage of (1) women's health care services, including contraception; (2) immunizations for children, adolescents, and adults; and (3) preventive services for children and youth age 21 or younger. This proposal passed unanimously in this committee and the senate last year, and I continue to support its passage.

Thank you for your time and attention, and I look forward to working with you on these important proposals.

Len Fasano
Senate Republican President Pro Tempore